Annex 14

Summaries of Selected Direct Investigation Assessments

HOSPITAL AUTHORITY ("HA")

Case No. OMB/DI/171

Management of Mortuaries in Hospitals under HA

(Assessment commenced on 22 April 2007 and completed on 16 November 2007)

Background

In April 2007, there was widespread media coverage about mix-up of the bodies of two deceased persons sharing the same compartment in the mortuary of the Prince of Wales Hospital ("PWH"). Concerned whether measures were in place to ensure proper identification for release of body, respect for the deceased and sensitivity to the feelings of relatives, The Ombudsman initiated this direct investigation assessment.

Procedures for Identification and Release

2. Hosp A has established procedures for collection of the deceased from the ward, documentation for body storage in the mortuary, checking of identification documents by mortuary staff, identification of the deceased by relative(s) or authorised representative, documentation for release of the body and release of the body.

Investigation Panel

3. An Investigating Panel set up by HA in response to the mix-up incident found the causes to be:

(a) a mortuary attendant's failure to comply with the established procedures to ascertain the identity of one of the bodies concerned was the main cause; and

(b) other contributing factors included –

(i) overcrowding of the mortuary leading to double occupancy;

(ii) the error of the wife of the deceased in identifying her late husband's body; and

(iii) the guidelines for collection and identification of bodies not being stringently enforced.

Improvement Measures

4. The Investigating Panel made the following recommendations for improving PWH's mortuary services:

(a) strengthening supervision, by random auditing, of mortuary staff's compliance with the guidelines;

(b) issuing instructions for identification of bodies;

(c) stepping up documentation and counterchecking of the body identification process;

(d) piloting a system for bar-coding bodies;

(e) augmenting PWH mortuary capacity from 56 to about 100 by the end of 2008; and

(f) encouraging early collection of bodies.

5. During the course of our inquiry, HA had extended these improvement measures to all its hospitals and started implementing them by phases. HA would also seek the cooperation of the Food and Environmental Hygiene Department to increase the capacity of cremation service, to cut the waiting time for cremation, thereby reducing the occupancy of mortuaries.

Comments and Conclusion

6. The mortuary attendant's non-compliance with the guidelines was inexcusable. In this connection, we noted that HA had introduced measures to strengthen supervision of mortuary attendants.

7. HA had responded promptly to the incident by setting up an Investigating Panel and undertaking a series of measures to improve mortuary services.

8. Given HA's proactive and positive efforts, The Ombudsman decided not to initiate a full-fledged direct investigation. We would monitor HA's full implementation of the improvement measures.

Annex 14

Summaries of Selected Direct Investigation Assessments

IMMIGRATION DEPARTMENT (“Imm D”)

Case No. OMB/DI/176

Immigration Department Application Forms for Foreign Domestic Helpers

(Assessment commenced on 1 November 2007 and completed on 18 March 2008)

Background – Media Criticism and Imm D Review

In response to media criticism in October 2005, Imm D had reviewed its multitude of application forms for foreign domestic helpers and concluded that five forms could be combined into one for visa or extension of stay application.

Delay in Implementation

2. Imm D’s intention then was to introduce the new form in tandem with the roll-out of its new Permits and Visas Application System (“P&V System”), scheduled for late 2006. The aim was to minimise confusion to the public and waste of the existing forms.

3. However, up to October 2007, no change had taken place, thus attracting further media criticism and this Office’s direct investigation assessment.

4. We found that as the contractor for the new P&V System had four times postponed the roll-out date of the System, Imm D had deferred the introduction of the new form.

Our Comments

5. We appreciate the need to minimise waste. We also accept that if possible, coinciding the launch of the new form with the new P&V System would have made for operational convenience. However, Imm D’s action in putting the scheme on hold for nearly two years had resulted in unduly prolonged public inconvenience.

6. Imm D could, and should, have introduced the new form on its own in the light of the P&V System contractor’s repeated postponement. This would have provided much earlier relief to the public.

Conclusion

7. Nonetheless, as the new form and a guidebook had been introduced in February 2008, The Ombudsman decided that a full-fledged direct investigation was not warranted.